SPECIALTY EYE INSTITUTE

PRE-PROCEDURE PATIENT EVALUATION FOR LASER REFRACTIVE PROCEDURES

COMAN

DOCTOR NAME: _____CONTACT PERSON: _____

PHONE #: _____ ADDRESS: _____

FAX#: _____ _____

PATIENT

LAST NAME: _____ FIRST: _____ MI: ____ ☐ M ☐ F

PHONE # HOME: _____ ADDRESS: _____

PHONE # WORK: _____ _____

DOB _____ AGE _____ SS# _____

FEE

TRADITIONAL PRICE QUOTED:$_____/EYE CUSTOM PRICE QUOTED:$_____/EYE

PRE/POST-OP COLLECTED? YES NO ; IF YES, AMOUNT COLLECTED: $_____

POST-OP AMOUNT: $_____/eye; INTRALASE DESIRED YES NO

LASIK INSURANCE: _____(fax copy)

SURGERY DATE: _____ TIME: _____ ONE-DAY POST-OP TIME: _____

PRE-OP EVAL

CURRENT RX: OD _____20/ OS _____20/

CYCLO: OD _____20/ OS _____20/

DRY: OD _____20/ OS _____20/

CYCLO DATE: _____ DRY DATE: _____ Pupil size dim____;illum____ Dom eye: OD / OS

*Contact lens use: DW SCL XW SCL Toric SCL RGP Contacts Removed Date: _____

Stable for 12 months (<0.50D) Yes No Pachymetry OD _____ OS_____

UCVA OD_____OS_____ K's OD: _____/_____@_____ OS: _____/_____@_____

OCULAR MEDICAL HISTORY:_____OCULAR SURGICAL HISTORY: _____

Medication Flags(please call if used within 6-months): Accutane, Amiodarone, Cordarone, Imitrex, Methotrexate, Prednisone, Topamax

CL Removal Guidelines Prior to Surgery: Soft Daily Wear 2 weeks, Soft Toric or Extended Wear 1 month, RGP minimum 1 month per decade of wear. Must confirm stability with refraction and topography.

EXAM

ANTERIOR SEGMENT:	***Lids/Conj***	***Cornea***	***Lens***	***IOP***
OD	clear/blepharitis	clear/opacities/neovasc/dystrophy	clear/opacities	_____mmHg
OS	clear/blepharitis	clear/opacities/neovasc/dystrophy	clear/opacities	_____mmHg

POSTERIOR SEGMENT:		***C/D***	***Myopic Degeneration***	***Peripheral Retina***
Dilated	OD	0.	none 1 2 3 4 severe	normal/ lattice/ pavingstone/ RD/ holes
	OS	0.	none 1 2 3 4 severe	normal/ lattice/ pavingstone/ RD/ holes

SUMMARY

Recommended Surgery: PRK ☐LASIK ☐PTK ☐BILATERAL ☐OD FIRST ☐OS FIRST

Recommended Platform: ☐ CUSTOM ☐ STANDARD ☐ INTRALASE ☐LTC ☐NO LTC

Aim: ☐Distance OU ☐Near OD ☐Near OS ☐Mono Target_____

Discussed: ☐Benefits & Risks ☐Presbyopia/Mono ☐ Enhancements

Comments: _____

_____Signature:_____

SEI Review:_____Date: _____